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	HFD12-0058	A. BUILDING _____ B. WING _____	R 02/29/2008

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MTS	1222 QUINCY ST, NE WASHINGTON, DC 20017

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I 000	INITIAL COMMENTS A monitoring survey was conducted on February 28, 2008 and February 29, 2008 to determine the facility's continued compliance with the deficiencies cited during the relicensure survey on October 16, 2007. The findings were based on observations, interviews and record review. New and continuing deficiencies were evidenced, as outlined in the report that follows.	I 000		
I 002	3500.2 GENERAL PROVISIONS Each GHMRP licensee and residence director shall demonstrate that he or she understands that the provisions of D.C. Law 2-137, D.C. Code, Title 6, Chapter 19 govern the care and rights of mentally retarded persons in addition to this chapter. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP licensee and residence director failed to demonstrate that he or she understood that the provisions of Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) govern the care and rights of mentally retarded persons. The findings include: 1. The facility failed to demonstrate protection of residents' rights to receive habilitation, care or both in order to facilitate access to services outside of the residential facility and/or to help them learn how to make choices necessary for daily living [Title 7, Chapter 13, § 7-1305.02, formerly § 6-1962], as follows:	I 002		

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DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2008 MAR 24 P 3:24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Asst. Director of Residential Services TITLE (X6) DATE 3/24/08

STATE FORM 6899 R3K311 If continuation sheet 1 of 27

PRINTED: 03/11/2008
FORM APPROVED

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I 002	Continued From page 1 a. Cross-refer to I422.3 and I422.4. The GHMRP failed to assist Residents #1 and #2 with accessing and participating in preferred community/ recreational services and activities. b. Cross-refer to I436. The GHMRP failed to ensure the habilitation and training of its residents in the area of self-medication administration. c. Cross-refer to I401. The GHMRP failed to evaluate Resident #1's non-compliance with nurse instructions, to develop programs to meet the resident's psychological and treatment needs. In particular, nursing staff had documented a consistent pattern whereby the resident was combative and/or refused to cooperate with finger sticks. The resident was diabetic and her primary care physician ordered finger sticks three time a week to monitor her blood glucose levels. There was no evidence that her combative behavior had been addressed by the interdisciplinary team, to include the psychologist, to develop formal or informal intervention strategies for nurses to use in dealing with the resident. It should be noted that on February 29, 2008, at approximately 7:35 AM, one direct support staff person was observed laughing inappropriately while assisting the nurse in obtaining Resident #1's finger stick. The staff presented a bottle of finger nail polish, telling the surveyor that the polish served as a distraction. The staff further indicated that they often used this strategy when the resident was uncooperative. During the process, which lasted approximately 6 minutes, the staff person laughed several times about the resident's behavior, in a playful manner and not in a tone that could be interpreted as mean-spirited). Nevertheless, she laughed about the resident's aversion to the finger sticks, and	I 002	1a. See responses for 1422.3 and 1422.4 1b. See responses for 1436 1c. the psychologist will develop a protocol for staff and nursing to follow in addressing Resident #1's resistance to finger sticks. The psychologist has already suggested an alternative to the finger stick method that will be less painful, quicker and easier because it is not focused to the finger. This new method will be incorporated into the protocol ... 3-30-08. Staff will be trained on the protocol and on their behavior/demeanor when providing support during the process (for example, no laughing) ... 3-30-08. The alternative tool will be purchased by ... 3-30-08.	

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I 002	Continued From page 2 spoke about the resident as if she were not present or was otherwise unable to understand what was being said. This practice did not promote the resident's dignity and respect. 2. The facility failed to demonstrate protection of residents' rights to receive habilitation, care or both in accordance with their Individual Support Plans (ISPs) [Title 7, Chapter 13, § 7-1305.04(c), formerly § 6-1964(c)], as follows: a. Cross-refer to I422.3 and I422.4. GHMRP nursing staff failed to implement Resident #1's physician's orders when they did not notify the primary care physician (or their nursing supervisors) when her blood glucose readings were below 80 or above 200. b. Cross-refer to I422.3 and I422.4. The GHMRP failed to implement Resident #1's and Resident #2's Activity Schedules and community outings as recommended in their ISPs. 3. The facility failed to demonstrate protection of residents' rights to receive a nourishing, well-balanced, varied and appetizing diet, and where ordered by a physician and/or nutritionist, to a specialized diet [Title 7, Chapter 13, § 7-1305.05(f), formerly § 6-1965(f)], as follows: Cross-refer to I422.2. GHMRP staff failed to implement Resident #1's and #2's diet orders. Resident #1, who was diabetic, and Resident #2 who was on a low fat diet, were both supposed to have sugar free ketchup and 1% milk. They were given regular ketchup and 2% milk instead. 4. The facility failed to demonstrate protection of residents' rights to receive prompt and adequate medical attention [Title 7, Chapter 13, §	I 002	2a. The Director of Nursing conducted refresher training with the nursing staff to insure that abnormal readings are reported immediately (see attachment)...3-20-08. Managing nurses will check the blood sugar levels at minimum weekly to insure that abnormal readings are routinely reported...3-30-08. The MAR documentation form will be modify to provide a reminder set of instructions to the nurses when they document the check. The modification will be done by...3-30-08. 2b. See responses for 1422.3 and 1422.4 3. The nutritionist reports that resident #1 and resident #2 can have regular ketchup (see: attached nutrition note)...3-20-08. There was no 1% milk in the home during the survey observation so staff inappropriately substituted the 2% milk. The facility manager will insure via menu-matched shopping that 1% milk is available at all times. The QMRP will observe at least two meals weekly and review the food/drink supplies against the planned menus at least once weekly to insure that each person receives the planned meal consistent with their prescribed diet on a routine basis...3-30-08. The nutritionist has conducted follow up training with staff including a review of proper substitutions (see: Attachment)...3-20-08.	

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I 002	Continued From page 3 7-1305.05(g), formerly § 6-1965(g)], as follows: Cross-refer to I422.1. There was no evidence that nursing staff notified the primary care physician (in accordance with physician's orders) or notified nursing supervisors (as reportedly instructed) when Resident #1's blood glucose levels tested below 80 or above 200. Documentation of finger sticks revealed that nurses recorded glucose levels out of range on 4 occasions in November 2007, once in December 2007, 4 in January 2008 and 3 times in February 2008 yet failed to follow procedures. 5. The facility failed to demonstrate protection of residents' rights to have their personal records kept complete and current [Title 7, Chapter 13, § 7-1305.12, formerly § 6-1972], as follows: a. Cross--refer to I292. The GHMRP failed to ensure that each resident's record included a summary of each significant contact by a professional person with a customer, and a complete summary of the customer's response to his or her program, prepared and recorded... by the Qualified Mental Retardation Professional. b. Cross-refer to I478. The GHMRP failed to maintain records of all controlled drugs received by residents, to include the date dispensed, amount and expiration date.	I 002	4. See responses for 3500.2 1b. 5a. See responses for 1292 5b. See responses for 1478	
I 024	3501.7 ENVIRONMENTAL REQ / USE OF SPACE Each GHMRP shall show that it can provide outside recreational activities. This Statute is not met as evidenced by:	I 024	3501.7 See responses for 142	

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I 024	Continued From page 4 Cross-refer to I422. The survey revealed no evidence that the GHMRP provided transportation and assistance to Resident #2 and her peers to attend church, nightclubs and other community-based social/ recreational activities, in accordance with their annual plans and interdisciplinary team recommendations.	I 024	3501.7 This is an area that needs improvement. The primary problem involved a dearth of approved drivers among the staff. This has been improved significantly (two approved drivers added) and the community activities will improve... 3-30-08. MTS has adjusted its recruiting strategies for direct care staff to insure that the majority of staff hired have driver's licenses and good driving records... 3-30-08.	
I 061	3502.19 MEAL SERVICE / DINING AREAS Each GHMRP shall have effective procedures for cleaning all equipment and work areas used in the preparation and serving of foods. This Statute is not met as evidenced by: Based on observation, the facility failed to implement effective procedures to ensure clean and sanitary equipment and work areas used for food preparation and serving. The finding includes: On February 29, 2008, at 8:10 AM, inspection of the kitchen revealed dried food particles and/or debris splashed on the back inside wall of the microwave oven.	I 061	3502.19 The QMRP trained staff on appropriate clean up after the am routine (see attachment)... 3-20-08. It should be noted that the am routine Monday through Friday is time compressed because of the day program runs. Staff clean up after breakfast but routinely return after the day program runs to complete the job thoroughly. The surveyor inspected before they returned to do so.	
I 062	3502.20 MEAL SERVICE / DINING AREAS Dishes and eating utensils shall be cleaned after each meal and stored to maintain their sanitary condition. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to store dishes in a manner that maintains proper sanitation.	I 062		

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I 062	Continued From page 5 The findings include: On February 29, 2009, at 8:19 AM, inspection of the kitchen cabinets revealed stacks of plastic drinking cups, plates and bowls. The Qualified Mental Retardation Professional, who was present at the time, indicated that the stacked dishes and cups were clean and ready for future use by the residents. Further inspection, however, revealed water that was trapped between the dishes and cups. One set of beverage glasses had milk trapped between them. In addition, two of the coffee mugs were stored upside down, with water trapped inside and no air flow to allow for drying.	I 062	3502.20 The facility dishwasher is broken and staff is assisting residents with hand dishwashing. The QMRP has trained staff on properly assisting residents with this task insuring that dishes are cleaned, sanitized and properly dried (See: Attachment). The broken dishwasher will be replaced by ... 3-30-08.	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the interior of the facility in a clean, orderly, and attractive manner. The findings include: On February 29, 2008, beginning at 8:08 AM, inspection of the facility revealed the following: Kitchen: 1. The interior sill below the kitchen window showed signs of water damage. Paint was	I 090	3504.1 Kitchen: 1. The window sill has been repaired ... 3-20-08. 2. When staff return from day program runs they routinely clean the interior of the microwave if it has been used. The QMRP covered this in her training ... 3-20-08.	

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I 090	Continued From page 6 chipped and/or missing. 2. There were dried food particles and/or debris splashed on the back inside wall of the microwave oven. Basement: 1. There were two ceiling tiles that were stained brown due to past water damage. 2. The area nearest the basement exit door was in disarray. There were old chairs, a window air conditioning unit, luggage and numerous other items piled in a haphazard manner. First floor bathroom: The caulking around the top edge of the bathtub was either missing or cracked, especially along the edge directly below the faucet and knobs. Upstairs bathroom in hallway: There was a large crack across the floor tiles and moulding along the edge of the floor tiles also was cracked.	I 090	Basement: 1. The ceiling tiles will be replaced by...3-30-08. 2. The basement floor had just been repaired and the materials cited were stacked as such so that the repairs could be done. The areas have been made orderly...3-20-08.	
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to store caustic agents in a locked cabinet. The finding includes:	I 095		

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I 095	Continued From page 7 On February 29, 2008 at 8:13 AM, a spray bottle of Mildew Soap cleaning agent and a jug of bleach were observed being stored in an unlocked cabinet under the kitchen sink.	I 095	3504.6 The QMRP will retrain staff on proper storage of poisons by ... 3-24-08. The facility manager will audit the physical environment weekly to insure that poisons are properly stored the designated locked area routinely ... 3-30-08.	
I 096	3504.7 HOUSEKEEPING No poisonous or hazardous agent shall be stored in a food preparation, storage or serving area. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to store caustic agents in a locked cabinet. The finding includes: On February 29, 2008, at 8:13 AM, a spray bottle of Mildew Soap cleaning agent and a jug of bleach were observed being stored in an unlocked cabinet under the kitchen sink. The Qualified Mental Retardation Professional, who was present at the time, immediately removed the poisons from the kitchen.	I 096	3504.7 See responses for 3504.6 above.	
I 292	3514.3 RESIDENT RECORDS Each record shall include, but not be limited to, the requirements of D.C. Law 2-137, D.C. Code § 6-1972 (1989 Repl. Vol). This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to maintain resident records in accordance with requirements of D.C. Law 2-137 (now Title 7, Chapter 13), for two of the four residents of the facility. (Residents #2 and #4)	I 292		

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I 292	Continued From page 3 The findings include: Title 7, Chapter 13; D.C. Code 7-1305.12 (formerly 6-1972) Complete records for each customer shall be maintained and shall be readily available to professional persons and to the staff workers who are directly involved... These records shall include: (8) "A medication history and status" See I478. Nursing staff failed to maintain accurate medication administration records for Residents #2 and #4. (9) "A summary of each significant contact by a professional person with a customer" a. On February 29, 2008, at 1:44 PM, review of Resident #2's medical record revealed Nursing Monthly Summary and Running Note entries indicating that she had a tooth extraction on January 29, 2008. The note entries did not, however, provide a complete summary of the dental visit. The resident's record did not include a January 29, 2008 dental consultation sheet. The survey revealed that the corresponding consult sheet had been placed in a "doctor's book," stored elsewhere in the facility. [Note: At 3:38 PM, further review of Resident #2's record revealed an annual physical, performed by the primary care physician (PCP) on February 26, 2008, that did not reflect the January 29, 2008 dental services. The Consulting RN acknowledged that the PCP had not seen the dental consult form when he was in the facility to perform the assessment, almost 1 month after the January 29, 2008 dental appointment.]	I 292	3514.3 (8). See responses for 1478 (9). MTS and revised and made routine its process for insuring that PCPs review consultation findings in a timely manner and document their recommendations. Nursing will meet with the PCP weekly on Tuesday's routinely to review all medical consultations for the week in a person-specific manner. The PCP will write their follow up note at that time and instruct the RN as to his/her recommendations and the disposition of the recommendations by the clinical specialist. The RN will write a companion note and insure that the consultation report, physician's note and the nursing note are placed in the medical record of the individual supported within the business week. The RN will use the new tracking format (attached) to insure that all recommendations are followed up in a timely manner and to report the status of follow up to the Director of Nursing...4-1-08.	

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I 292	Continued From page 9 b. On February 29, 2008, at 3:38 PM, review of Resident #2's annual physical, dated February 26, 2008, revealed a reference made by the PCP to a September 13, 2007 pap smear. This was the only indication in the record that the resident had received a pap smear. The Consulting RN was unable to locate the corresponding consultation form for the September 13, 2007 gynecology examination. [Note: A post-survey telephone interview with the PCP (March 3, 2008, at 12:12 PM) revealed that he recalled a September gynecology appointment, the findings reflected fibroids. He thought perhaps the corresponding consult form might still be doctor's book; however, review of the book had shown no evidence of the consult form.] (10) "A summary of the customer's response to his or her program, prepared and recorded... by the professional person designated... to supervise the customer's habilitation." On February 29, 2008, at approximately 5:00 PM, review of Resident #2's habilitation record revealed that the QMRP had prepared quarterly reports in which she summarized the resident's response to her programs. However, further review of the quarterly summaries revealed no evidence that the QMRP had reviewed Resident #2's progress (or lack of progress) on all training programs outlined in her annual plan. For example, the quarterlies did not reflect the following programs: cleaning and polishing her shoes, using the bathroom independently, identifying pictures, and brushing her teeth independently after dinner.	I 292	b. There was no 9-13-08 pap smear. On 9-13-08 resident #2 had a mammogram (copy attached). Resident # 2 visited GYN on 4-30-08 (copy attached). The GYN visits resulted in no significant issues noted and a recommendation that she return in 2 years. The fibroid issue is mentioned on the most current medical assessment for resident #2 and goes back to 2005. The fibroids are indicated to be "asymptomatic" and no issues were raised as mentioned earlier during the 4-30-08 GYN. Nursing will follow up as needed and as recommended to insure proactive monitoring of the issue and timely treatment in it becomes necessary...3-30-08. The QMRP will insure that all formal training programs are reviewed in data-based fashion and that none of missed...3-30-08. The executive director will insure routine compliance via peer audits, audits by the Assistant and by the executive director herself periodically...4-15-08.	
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS	I 401		

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I 401	Continued From page 10 Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to evaluate Resident #1's non-compliance with nurse instructions, to develop programs to meet the resident's psychological and treatment needs. The findings include: 1. On February 29, 2008, at 7:33 AM, the medication nurse asked staff to bring Resident #1 to the dining room for testing her blood sugar levels and to administer medications. The nurse immediately turned to this surveyor and stated "here comes the fight... finger stick... fights so bad... sometimes she refuses." Indeed, Resident #1 saw the finger stick device and immediately began resisting efforts to lance the finger. Two direct support staff intervened, assisting the nurse by talking with the resident and applying nail polish to her other hand. The resident struggled for approximately 5 minutes before the nurse managed to obtain blood. The direct support staff said Resident #1 was often combative and that there were times when the nurse was unable to achieve a finger stick. Resident #1's records were reviewed later that morning, beginning at 11:25 AM. Her psychological assessment, dated August 2007, did not reflect any concerns regarding refusals to cooperate with finger sticks. Her Behavior Support Plan (BSP), dated February 12, 2007,	I 401	3520.3 1. As mentioned earlier, the finger stick compliance issue will be addressed via the use of an alternative instrument to obtain the blood sugar levels. The new tool will be in place by ... 3-30-08.	

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I 401	Continued From page 11 also did not reflect refusals to have finger sticks. [Note: The BSP included "non-compliance" in a list of targeted behaviors; however, non-compliance was not defined.] At 11:59 AM, review of Resident #1's finger stick charts revealed that nursing staff had documented the following: October 2007: blood glucose readings were not achieved on 6 occasions that month (on 10/1, 10/5, 10/8, 10/10, 10/28 and 10/31) due to the resident's refusals. The nurse documented combative behavior on 3 other occasions (on 10/3, 10/12 and 10/24); however, they recorded having obtained blood sugar readings. [Note: There were 4 other readings taken that month for which no behavior was indicated.] November 2007: she was combative on 9 out of 20 attempts; 8 times the nurse was unable to obtain a blood sample. 2. During both the evening medication pass on February 28, 2008 and the medication pass observed the next morning, the nurse stirred apple sauce into Resident #1's medications and spooned the mixture into the resident's mouth. She was not asked or encouraged to take the spoon by hand to participate in the process. However, the resident was observed eating her dinner independently with a fork on February 28, 2008. At 12:14 PM, the facility's consulting RN was asked about Resident #1's combative behavior. She confirmed that it is a frequent issue, adding "as soon as she sees you bring out the instrument, the fight is on." She also stated that the reason the nurses spoon fed the resident was	I 401	2. Resident #1 can and will eat the applesauce with the medications in it without assistance. The QMRP, facility manager and Director of Nursing all confirm this. The Medication LPN will be retained on proper implementation of the self medication program. The DON or Lead RN will complete the training by ...3-30-08.	

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I 401	Continued From page 12 that Resident #1 "won t do it... she will not" use the spoon herself because she knows the medications are mixed in with the apple sauce. A minute later, the RN reviewed the resident's record and confirmed that there was no evidence of a self-medication assessment. At approximately 12:35 PM, the Qualified Mental Retardation Professional (QMRP) looked in Resident #1's record and could not find a self-medication assessment. She was aware that the resident was combative. The QMRP and RN described a recent event when Resident #1 was uncooperative with attempts to draw blood at a hospital, stating there was need for "4 security guards to hold her down for blood work... she is strong!" Further interview with the QMRP confirmed that the resident's combative behavior (at finger sticks, or spooning medications) had not been brought to the psychologist's attention for assessment and/or development of a formal intervention strategy to assist the resident and staff with meeting her medical needs.	I 401	The DON, Lead RN and QMRP will periodically monitor medication administration to insure that the individuals supported are allowed to participate consistent with their self medication programs to the fullest extent possible ... 4-1-08. Resident #1 is combative about the finger stick issue consistently but is not combative otherwise. Her medical needs are otherwise routinely met. The DON and RN will insure that each person supported has a self medication assessment in their medical record by ... 3-30-08. They supported by the QMRP will insure that self medication assessments are updated routinely in conjunction with the ISP development process ... 4-30-08.	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide habilitation and assistance in accordance with residents' Individual Support Plans (ISPs), for two of the two residents in the sample. (Residents #1 and #2) The findings include: 1. GHMRP nursing staff failed to implement	I 422		

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I 422	Continued From page 13 Resident #1's physician's orders, as follows: On February 29, 2008 at approximately 7:38 AM, the medication nurse took a reading of Resident #1's blood sugar levels. The nurse stated that it was at 137, within normal limits. Resident #1's records were reviewed later that morning, beginning at 11:25 AM. Her physician's orders (POS) from November and December 2007, and January and February 2008, included the following: "check blood glucose level (finger stick) three times weekly (M, W and F). Notify the MD if glucose level is <80 or >200." At 11:59 AM, review of Resident #1's finger stick charts revealed abnormal blood glucose readings on 4 occasions in November 2007, once in December 2007, 4 in January 2008 and 3 more times in February 2008. The chart on which the finger sticks were recorded also provided a space designated for documenting the notification of Resident #1's doctor. However, the 4 monthly charts did not reflect any documented notifications of the doctor when glucose readings fell outside of the range specified in the POs. At 1:25 PM, the Consulting RN was asked how nursing staff should respond to Resident #1's blood sugar readings if they are outside of the range specified in her POs. Nurses reportedly had been instructed to notify the Consulting RN and she would then contact the primary care physician (PCP). At 6:10 PM, further interview with the Consulting RN revealed that she would expect the nurse to document having notified her in the resident's running nurse notes. The RN and Qualified Mental Retardation Professional (QMRP) both stated that they had not been notified of any finger sticks in recent months	I 422	3521.3 1. The DON retrained nursing on the importance of insuring proper notification to the PCP when abnormal values and levels are discovered or taken...3-30-08. The Lead RN will check the data at minimum weekly to insure ongoing compliance...4-1-08. The weekly PCP/nursing reviews will also improve communication on such concerns...4-1-08.	

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I 422	Continued From page 14 when the glucose readings were below 80 or above 200. When informed that Resident #1's readings in January 2008 had been as high as 370 (on 1/4/08) and 267 (on 1/9/08), the Consulting RN suggested that the nurses had called the Nurse Admin strator instead of her. Follow-up telephone interviews on March 3, 2008 with the Nurse Administrator and the PCP, at 11:10 AM and 12:12 PM respectively, confirmed that neither had been notified that Resident #1's blood glucose readings had fallen out of range in recent months. 2. GHMRP staff failed to implement Resident #1's and #2's diet orders, as follows: On February 28, 2008, beginning at 6:08 PM, Resident #1 and her peers were observed eating hot dogs and hamburgers at dinner. There was one bottle of ketchup brought to the table, Richfood (regular, with high fructose corn syrup and sugar) that was used by all. The next morning, staff stated that all residents had been given a glass of milk with their breakfasts (served prior to this surveyor's arrival). At 8:10 AM, observation of the refrigerator revealed a bottle of Richfood ketchup and a gallon of 2% milk, with the date 2/27/08 written on the jug with magic marker. When asked, the QMRP indicated that all of the residents drank the same milk. Earlier that morning, at 7 33 AM, it was revealed that Resident #1 was diabetic, and her blood sugar levels were tested 3 times a week. This was later confirmed by review of the resident's physician's orders, at 11:48 AM. Resident #1 was prescribed an "1800 calorie diabetic diet." At 3:57 PM, review of Resident #2's February 2008 physician's orders revealed that she was prescribed a "regular, low fat, low sodium" diet.	I 422	2. The nutritionist did not restrict resident #1 on regular ketchup and when the survey citation was shared with her, she indicated that resident #1 can have regular ketchup on things like hot dogs (see: attached note from the nutritionist)... 3-20-08. The facility manager will insure that 1% milk is available for the individuals for whom it is prescribed routinely. The facility manager will insure all shopping is matched to the prescribed menus and diets... 3-30-08. Staff will be retrained on following the prescribed diets/menus... 3-30-08. The facility manager and QMRP separately will observe at minimum two meals weekly (QMRP) or three (facility manager) to insure routine compliance... 3-30-08.	

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I 422	Continued From page 15 At approximately 5:57 PM, review of the menus revealed that residents on low fat and/or 1800 calorie diabetic diets should drink 1% milk. Further review of the previous evening's menu revealed that residents on 1800 calorie diabetic diets should use "sugar free" ketchup. At 6:01 PM, the direct support staff person in the kitchen stated that the ketchup in the refrigerator was "probably not" sugar free, and there was no other ketchup available in the GHMRP. 3. The GHMRP failed to implement Resident #2's Activity Schedule and community outings as recommended by her interdisciplinary team (IDT) in her April 8, 2007 ISP, as follows: On Thursday, February 28, 2008, at approximately 4:07 PM, a February 2008 calendar was posted in the center hallway. The word Chateau was written on the calendar for every Thursday. At approximately 4:20 PM, interview with a direct support staff person revealed that the ladies enjoyed dancing at The Chateau nightclub; however, they would not go there that evening because they were celebrating Resident #2's birthday in the facility. On February 29, 2008, at approximately, 6:50 AM, Resident #2 confirmed that they had all stayed home the night before. On February 29, 2008, beginning at 4:34 PM, review of Resident #2's Program Book revealed a "Recreation Data Collection Sheet" on which staff had documented few (9) community/ recreational outings during the past 3 months, as follows: Sat. December 8, 2007 - Publick Playhouse Sat. December 15, 2007 - Greenbelt Mall Sun. December 23, 2007 - church	I 422	3. It was not inappropriate for staff and the people supported to alter the outing plans for one evening in order to celebrate the birthday of a peer. The QMRP and facility manager will insure that planned outings are implemented and are aided by the recent hire of two driver-eligible staff for the home ... 3-30-08. The executive director will review routine compliance during her monthly one-to-one meetings with the QMRP ... 4-1-08.	

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I 422	Continued From page 16 Tues. December 25, 2007 - church Sat. January 12, 2008 - Greenbelt Mall, movie Sat. January 26, 2008 - Wheaton Plaza shopping Sun. January 27, 2008 - church Fri. February 8, 2008 - dinner with 14th St. peers Wed. February 13, 2008 - dinner at IHOP At 4:38 PM, review of Resident #3's April 8, 2007 ISP revealed a list of things that she enjoyed doing, including "going to church" and "going to The Chateau." Her IDT recommended that she "participate in a variety of social and recreational activities." The ISP included an Activity Schedule, dated March 8, 2007, that reflected Saturday and Sunday activities outside of the group home, as follows: Sat. 2PM-6PM outing 6PM-7PM dinner/meds (eat out) Sun. 9AM-1PM church 3PM-6PM sightseeing Resident #2's program book included "Direct Care Progress Notes," forms on which staff documented what occurred during each shift. At 5:06 PM, review of the staff progress notes from January - February 2008 revealed no evidence of additional recreational outings that were not reflected on the Recreation Data Sheets. At 5:48 PM, the Facility Manager and the QMRP were asked how long ago the ladies had been to The Chateau. The Facility Manager did not offer a response; however, the QMRP stated "they usually go once a month." The QMRP also stated that the GHMRP had its own vehicle available, therefore transportation would not be a reason for the residents to stay home on weekends.	I 422		

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I 422	Continued From page 17 There was no evidence that the GHMRP assisted Resident #2 with participating in a variety of recreational activities, in accordance with her ISP and Activity Schedule. There was no documented evidence that she had been to church in February 2008 or gone to The Chateau nightclub within the past 3 months. 4. On February 29, 2008, beginning at 5:15 PM, review of Resident #1's Activity Schedule and Recreation Data Collection Sheets revealed findings similar to those cited above, for Resident #2. Her Activity Schedule included Saturday outings (lunch, shopping, etc.) and Sunday (church and sightseeing). Staff had documented mostly the same outings as Resident #2; she did not attend the February 8, 2008 dinner with peers. There was no evidence that Resident #1 participated in community outings at the prescribed frequency.	I 422		
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the habilitation and training of its residents in the area of self-medication administration. The findings include:	I 436		

PRINTED: 03/11/2008
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I 436	Continued From page 18 Observation of the evening medication administration on February 28, 2008, beginning at 5:49 PM, revealed the following: 1. Resident #1 received her medications first. The nurse asked a direct support staff person to bring the resident's beverage cup to the dining room table, which the staff did. The nurse emptied a packet of Metamucil powder into the resident's cup, poured water and then stirred. The nurse also removed the resident's medications from their respective bubble packs into a small plastic med cation cup, and then stirred in some apple sauce. Resident #1, who had been elsewhere in the facility, was then brought to the dining room table. The nurse held the spoon and spooned the medication/apple sauce mixture into the resident's mouth, She then handed the beverage cup to the resident, who took the cup and drank the Metamucil solution. The resident placed the empty cup on the table and promptly walked away. On February 29, 2008, the Medication Administration Record (MAR) book was reviewed, beginning at 12:10 PM. Along with Resident #1's current (February 2008) MAR was a data collection sheet for a program with the stated "Goal: To improve self-medication skills." The data sheet reflected 2 steps: the resident was to pour her water before taking her medications and take the empty cup to the kitchen. The data sheet, however, was for the month of January 2008. There was no comparable data sheet for February. The Consulting RN was present at the time of the review. Initially, she stated that the residents did not have training programs, per se, but were	I 436	3521.7 (f) As indicated, the DON retrained the medication administration nurse on implementing the self medication programs and will monitor ongoing compliance in support of the Lead RN and QMRP...3-30-08. Also as indicated earlier, nursing and the QMRP will insure that self medication assessments are in place for each person supported, that each has a program that reflect their current skill levels and potential for growth and that assessments are updated annually during the ISP development process...4-30-08.	

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I 436	Continued From page 19 expected to participate by pouring their water and take their cups to the k tchen. When asked if their self-medication skills had been assessed, the RN replied yes, this was a part of the annual nursing assessment process. There was no self-med assessment observed in the record. At 12:28 PM, the RN looked through Resident #1's record and acknowledged that she was unable to locate a self-medicatior assessment in the record. The RN summoned the QMRP from the basement. At approxim ately 12:35 PM, the QMRP also stated that she was unable to locate a self-medication assessment in Resident #1's chart. Further review of the record revealed no documented evidence that self-medication training was included in Resident #1's annual plan. 2. During the evening medication pass on February 28, 2008, at 6:08 PM, the nurse removed Resident #2's medications from their bubble packs into a small plastic medication cup and then handed the medications to the resident. The nurse then instructed the resident to drink from a cup of juice that had been poured earlier by another resident. The resident drank some juice and then sat at the dinner table. On February 29, 2008, at 4:04 PM, review of Resident #2's records revealed similar findings as those obtained through review of Resident #1's record earlier that day. There was no assessment and there was no training goal or objective specified in Resident #2's annual plan.	I 436		
I 478	3522.6(d) MEDICATIONS The record for a resident ' s prescribed controlled substances shall include the following: (d) Date dispensed, amount and expiration date;	I 478		

PRINTED: 03/11/2008
FORM APPROVED

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I 478	Continued From page 20 and... This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain records of all controlled drugs, to include the date dispensed, amount and expiration date. The findings include: The four residents' Medication Administration Records (MARs) were reviewed on February 29, 2008, beginning at approximately 1:16 PM, to verify the medication pass that was observed on the previous evening. The review revealed numerous documentation errors and/or omissions in the MARs, as follows: 1. Resident #4's Mirtazepine (Remeron) 30 mg tabs had been unavailable for administration on the previous evening. The nurse stated that the supply had run out that day. Review of Resident #4's MAR at 1:30 PM the next day, however, revealed that the nurse had initialed the MAR as if the Remeron had been administered. She made no notation indicating that the medication was unavailable. At 1:34 PM, the Consulting RN confirmed that there was no Remeron in the facility. The RN examined the MAR and confirmed that the nurse had not documented the missed medication appropriately. Further interview revealed that the RN was previously unaware that Resident #4 had not received the medication, and there was no evidence that the primary care physician was informed of the missed medication. 2. On February 29, 2008, at 1:44 PM, review of Resident #2's Nursing Monthly Summary and Running Notes for January and February 2008	I 478	3522.6 (d) 1. The DON has reviewed the Remeron situation with the relevant medication nurse, counseled her on proper documentation, notification and follow up and may have other follow up actions pending the results of her investigation of all of the issues raised under 3522.6 (d)...3-30-08.	

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I 478	Continued From page 21 revealed that on January 29, 2008, a nurse administered 2 tabs of Tylenol #3 (a Schedule III narcotic) for pain, following dental surgery on that date. The same nurse wrote a note documenting that she had administered another 2 tabs of Tylenol #3 on the following day. Subsequent review of the Tylenol #3 revealed numerous errors, as follows: a. Review of Resident #2's January 2008 MAR revealed no indication that the Tylenol #3 had been administered on either date. At approximately 1:50 PM, the Consulting RN examined the MAR and confirmed that the nurse had not documented the administration of Tylenol #3 appropriately. b. Resident #2's medical chart failed to show evidence of a physician's order for the use of Tylenol #3 for January 29, 2008 or January 30, 2008. c. Review of the January 29, 2008 dental consultation sheet revealed that the dentist had recommended that Resident #2 receive "Motrin for discomfort as directed." There was no evidence that a licensed physician had authorized the use of Tylenol #3 on January 29, 2008 or January 30, 2008. d. The original Tylenol #3 prescription had been filled on October 2, 2007, following a tooth extraction. In its licensure deficiency report dated October 16, 2007, the Health Regulation Administration cited the facility's failure to properly document the administration of Tylenol #3 (see below). A follow-up review of the Controlled Medication Utilization Record (CMUR) form on February 29, 2008, at 1:38 PM, revealed continued failure to perform periodic	I 478	2. The DON is conducting a full investigation of the Tylenol #3 issue and will recommend appropriate action upon completion of her investigation. The 12 pills discussed by the survey were in a locked box that was not stored in the medication cabinet. They will be properly destroyed with the record properly reconciled ... 3-208. The lead RN will review the MARs, medication nursing notes, and medication cabinets at minimum weekly to audit for the concerns outlined. Appropriate action will be taken when issues are uncovered up to and including the replacement of nursing supports if that is deemed necessary ... 3-30-08. The lotion for resident #3 has been properly disposed of ... 3-20-08. The support LPNs will audit the personal care kits of the individuals supported bi-monthly and the facility manager will do so weekly to insure that topical creams are current, properly labeled and properly used at all times as well as disposed of properly when that is necessary ... 3-30-08.	

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I 478	Continued From page 22 reconciliation of the Tylenol #3 and to properly document its administration. The CMUR had not been updated since October 9, 2007, at which time there were reportedly 12 tablets remaining. Inspection of the locked medication cabinet on February 29, 2008 revealed no evidence that Tylenol #3 remained on the premises. The resident's October 2007 MAR indicated that she had been administered Tylenol #3 on October 15, 2007 (reason not specified). There were nurse running notes indicating that on January 29 and 30, 2008, additional Tylenol #3 had been administered; however, these were not reflected on the January 2008 MARs. There was no written record/accounting for what had happened to the 12 pills that remained on October 9, 2007. This is a repeat deficiency. ********** Previously, the October 16, 2007 survey findings included the following: Observation of the medication pass was conducted on October 15, 2007 beginning at 9:40 AM. The facility's Medication Administration Record (MAR) was reviewed on October 15, 2007 at 11:07 AM. Review of the "Controlled Medication Record" revealed that Resident #3 was administered Tylenol #3, several days for a swollen jaw. Further review of the "Controlled Medication Record" revealed that there was no documented evidence of the month that the Tylenol #3 was administered to the resident. There was no evidence that the facility maintained all controlled drugs records with the date dispensed and amount.	I 478		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0058	A. BUILDING _____ B. WING _____	R 02/29/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 484	Continued From page 23	I 484		
I 484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that all prescribed medications, including topical lotions, were destroyed when they reached their expiration date. The finding includes: On February 29, 2008, at approximately 8:40 AM, a bottle of Ammonium Lactate 12% lotion was observed on Resident #3's dresser top. The bottle's label included the following: "discard after January 30, 2008." The Qualified Mental Retardation Professional, who was present at the time, confirmed that the lotion's expiration date had passed.	I 484		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the protections of each resident's rights. The findings include:	I 500		

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I 500	Continued From page 24 1. The facility failed to demonstrate protection of residents' rights to receive habilitation, care or both in order to facilitate access to services outside of the residential facility and/or to help them learn how to make choices necessary for daily living [Title 7, Chapter 13, § 7-1305.02, formerly § 6-1962], as follows: a. Cross-refer to I422.3 and I422.4. The GHMRP failed to assist Residents #1 and #2 with accessing and participating in preferred community/ recreational services and activities. b. Cross-refer to I436. The GHMRP failed to ensure the habilitation and training of its residents in the area of self-medication administration. c. Cross-refer to I401. The GHMRP failed to evaluate Resident #1's non-compliance with nurse instructions, to develop programs to meet the resident's psychological and treatment needs. In particular, nursing staff had documented a consistent pattern whereby the resident was combative and/or refused to cooperate with finger sticks. The resident was diabetic and her primary care physician ordered finger sticks three time a week to monitor her blood glucose levels. There was no evidence that her combative behavior had been addressed by the interdisciplinary team, to include the psychologist, to develop formal or informal intervention strategies for nurses to use in dealing with the resident. It should be noted that on February 29, 2008, at approximately 7:35 AM, one direct support staff person was observed laughing inappropriately while assisting the nurse in obtaining Resident #1's finger stick. The staff presented a bottle of finger nail polish, telling the surveyor that the polish served as a distraction. The staff further	I 500	3523.1 1a. See responses for 1422.3 and 1422.4 b. Se responses for 1436 c. See responses for 1401	

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I 500	Continued From page 25 indicated that they often used this strategy when the resident was uncooperative. During the process, which lasted approximately 6 minutes, the staff person laughed several times about the resident's behavior, in a playful manner and not in a tone that could be interpreted as mean-spirited). Nevertheless, she laughed about the resident's aversion to the finger sticks, and spoke about the resident as if she were not present or was otherwise unable to understand what was being said. This practice did not promote the resident's dignity and respect. 2. The facility failed to demonstrate protection of residents' rights to receive habilitation, care or both in accordance with their Individual Support Plans (ISPs) [Title 7, Chapter 13, § 7-1305.04(c), formerly § 6-1964(c)], as follows: a. Cross-refer to I422.1. GHMRP nursing staff failed to implement Resident #1's physician's orders when they did not notify the primary care physician (or their nursing supervisors) when her blood glucose readings were below 80 or above 200. b. Cross-refer to I422.3 and I422.4. The GHMRP failed to implement Resident #1's and Resident #2's Activity Schedules and community outings as recommended in their ISPs. 3. The facility failed to demonstrate protection of residents' rights to receive a nourishing, well-balanced, varied and appetizing diet, and where ordered by a physician and/or nutritionist, to a specialized diet [Title 7, Chapter 13, § 7-1305.05(f), formerly § 6-1965(f)], as follows: Cross-refer to I422.2. GHMRP staff failed to implement Resident #1's and #2's diet orders.	I 500	2a. See responses for 1422.7 b. See responses for 1422.3 and 1422.4	

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I 500	Continued From page 26 Resident #1, who was diabetic, and Resident #2 who was on a low fat diet, were both supposed to have sugar free ketchup and 1% milk. They were given regular ketchup and 2% milk instead. 4. The facility failed to demonstrate protection of residents' rights to receive prompt and adequate medical attention [Title 7, Chapter 13, § 7-1305.05(g), formerly § 6-1965(g)], as follows: Cross-refer to I422.1. There was no evidence that nursing staff notified the primary care physician (in accordance with physician's orders) or notified nursing supervisors (as reportedly instructed) when Resident #1's blood glucose levels tested below 80 or above 200. Documentation of finger sticks revealed that nurses recorded glucose levels out of range on 4 occasions in November 2007, once in December 2007, 4 in January 2008 and 3 times in February 2008 yet failed to follow procedures. 5. The facility failed to demonstrate protection of residents' rights to have their personal records kept complete and current [Title 7, Chapter 13, § 7-1305.12, formerly § 6-1972], as follows: a. Cross-refer to I292. The GHMRP failed to ensure that each resident's record included a summary of each significant contact by a professional person with a customer, and a complete summary of the customer's response to his or her program, prepared and recorded... by the Qualified Mental Retardation Professional. b. Cross-refer to I478. The GHMRP failed to maintain records of all controlled drugs received by residents, to include the date dispensed, amount and expiration date.	I 500	3. See responses for 1422.2 4. See responses for 1422.1 5. See responses for 1292 b. See responses for 1478.	